Glossary

1115 (c) Waiver is a vehicle by which the Centers for Medicare & Medicaid Services (CMS) may waive certain Medicaid and Children's Health Insurance Program (CHIP) regulations, allowing a state to test new or existing ways to deliver and pay for health care services under these two programs. In Indiana, the Healthy Indiana Plan (HIP) operates under an 1115 (c) waiver.

1634 Status is a federal designation given to states for determining Medicaid eligibility for the aged, blind, and disabled populations. Under this program, recipients of Supplemental Security Income (SSI) through the federal Social Security Administration (SSA) obtain automatic Medicaid enrollment and need not complete a separate state Medicaid application. In addition, 1634 Status states may, but are not required to, operate a Medicaid spend-down program. Indiana became a 1634 Status state in 2013.

Actuarial Value (AV) is the average percentage of allowed medical cost expected to be paid by a health plan over all covered enrollees. All health plans offered on and off of the federal Marketplace in the individual and small group markets are required to meet certain AV standards that are to be displayed to consumers. In general, plans with higher AVs will have higher premiums and lower cost sharing.

Affordable Care Act (ACA) (also known as **Patient Protection and Affordable Care Act (PPACA)** or **Obamacare**) is a federal statute that was signed into law (Public Law 111-148) by President Barack Obama on March 23, 2010 and later amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152). The law provides fundamental reforms to the United States healthcare and health insurance systems, including the establishment of health insurance Marketplaces and federal consumer assistance programs (such as federal Navigators, CACs, and non-Navigator Assistance Personnel).

Agent (also known as **Broker** or **Producer**) is an individual or business entity licensed by a state to sell, solicit, or negotiate insurance products within the state. A licensed insurance agent/broker/producer who sells health insurance products or receives compensation from a health insurance carrier is prohibited from being an Indiana Navigator or Application Organization (AO) in the State of Indiana. A licensed insurance agent/broker/producer that sells health insurance products on the federal Marketplace must be certified by the federal Marketplace.

Aid Category (see **Eligibility Group**)

Advanced Premium Tax Credit (APTC) (see **Premium Tax Credit (PTC)**)

Appeal is a consumer's right to request an evaluation and re-determination of the consumer's health plan eligibility or features. An appeal of Indiana Medicaid eligibility or benefits can be made to the Indiana Division of Family Resources (DFR) in a manner specified in the DFR denial/change notice. An appeal of federal Marketplace eligibility or benefits can be made via an Appeal Request Form located at www.healthcare.gov/downloads/marketplace-appeal-request-form-a.pdf. Appealable decisions are specified on the form.

Applicable Large Employer is, with respect to a calendar year, an employer that employed an average of at least 50 full-time employees (including full-time equivalent employees) on business days during the preceding calendar year. Such an employer is eligible to enroll in the SHOP Marketplace and would not be subject to the employer shared responsibility payments.

Application Organization (AO) is an organization that has employees and/or volunteers helping Hoosier insurance consumers complete applications for health coverage through the federal Marketplace or Indiana Health Coverage Programs (such as Medicaid, the Children's Health Insurance Program (CHIP), or the Healthy Indiana Plan (HIP)). Organizations meeting the definition of "application organization" under Indiana Code 27-19-2-3 must be registered with the Indiana Department of Insurance (IDOI).

Authorized Representative is an individual or organization designated by a Medicaid or insurance affordability program applicant or beneficiary to act responsibly on his or her behalf to assist with the individual's application and renewal of eligibility and other ongoing communications. Authorized representatives may be authorized to sign an application on the applicant's behalf, complete and submit a renewal form and receive copies of the applicant or beneficiary's notices and other communications from the Medicaid agency.

Auto Assignment is the process by which an individual who does not select a Hoosier Healthwise (HHW) or Healthy Indiana Plan (HIP) Managed Care Entity (MCE) at the time of the HHW or HIP application, or within fourteen (14) days of the submission of the application, is automatically assigned to a Managed Care Entity.

Behavioral and Primary Healthcare Coordination Program (BPHC) is a program that provides access to Medicaid Rehabilitation Option (MRO) services to individuals with Serious Mental Illness (SMI) whose income would otherwise be too high to qualify for Medicaid coverage. A person deemed eligible for BPHC receives full Medicaid benefits.

Benefits (see **Health Insurance**)

Benefits Portal is a website developed and managed by the Indiana Department of Family Resources (DFR) by which Hoosier insurance consumers may apply for Indiana Health Coverage Programs (IHCPs) as well as check the status of pending applications. The DFR Benefits Portal is located at www.ifcem.com/CitizenPortal/application.do.

Best Door refers to a consumer's decision to either complete the Indiana Application for Health Coverage (IAHC) or the federal Marketplace application for health coverage based on certain eligibility criteria (e.g., Table 65, Table 66, and Table 67) determined by the consumer and/or the application assister (e.g., Indiana Navigator) assisting the consumer.

Broker (see **Agent**)

Bronze Plan is a type of Qualified Health Plan (QHP) offered to consumers on a Marketplace. It is designed so that an insurance carrier will pay 60% of covered healthcare expenses with the remaining 40% to be paid by the consumer. The consumer's expenses will be in the form of out-of-pocket fees over and above the cost of the plan's monthly premium (which is the lowest of the three QHPs/Metal Plans offered in Indiana). Out-of-pocket expenses in 2014 are capped at $6,350 for individual plans and $12,700 for family plans.

Care Management Organization (CMO) is an organization contracted with Indiana Health Coverage Programs (IHCPs) to perform the care management, prior authorization, and utilization management of physical, behavioral, and transportation services for members in Care Select. The CMO manages care for Care Select members through its network of Primary Medical Providers (PMPs), specialists, and other providers. Currently, MDwise and Advantage Health Solutions serve as Indiana's Care Management Organizations.

Care Select is an optional health care program for Indiana Medicaid enrollees who have special health needs or would benefit from specialized attention. Care Select includes comprehensive care coordination for members. Individuals eligible for Care Select include those who are eligible for Medicaid on the basis of being aged, blind, disabled, a ward of the court or foster child, or a child receiving adoptive services or adoption assistance and have a specific medical condition.

Catastrophic Plan is a health plan available on and off the federal Marketplace for individuals who are under the age or 30 or who received an exemption from the Individual Mandate to maintain Minimum Essential Coverage (MEC). It is exempt from Actuarial Value (AV) requirements. The individual is responsible for most healthcare costs until deductible/out-of-pocket maximum is met. It qualifies as MEC for the Individual Mandate, and the individual is not eligible for Premium Tax Credits (PTCs) or Cost-sharing Reductions (CSRs).

Centers for Medicare & Medicaid Services (CMS) is a federal agency within the U.S. Department of Health and Human Services (HHS) that administers Medicare, works in partnership with state governments to administer Medicaid and the Children's Health Insurance Program (CHIP), and oversees Healthcare.gov.

Certificate of Coverage is a list of benefits, services, cost-sharing, exclusions, and limits applied by a particular health insurance policy.

Certified Application Counselor (CAC) is a federal consumer assistant, established under the ACA and 45 C.F.R. 155.225, who is certified under a federally-designated CAC organization to provide Marketplace education and enrollment assistance. If an organization is designated by the federal government as a CAC organization on the federal Marketplace operating in Indiana, the organization must also be registered as an AO with the Indiana Department of Insurance (IDOI). If an individual is certified as a federal CAC under a federally-designated CAC organization, the individual must also be certified as an Indiana Navigator with the Indiana Department of Insurance.

Child-only Policy (or "Child-only Plan") is an Individual Market policy that is sold a child under the age of nineteen. Child-only Policies do not include policies that are sold to adults with children as dependents.

Children's Health Insurance Program (CHIP) is a health coverage program for children authorized in 1997 under Title XXI of the Social Security Act. CHIP provides health coverage to children whose income is too high to qualify for Medicaid. CHIP is administered by states with joint funding from the federal government and the states. States can implement CHIP though a Medicaid expansion, separate CHIP or combination of the two approaches. Indiana operates CHIP through both a Medicaid expansion and separate CHIP program.

Churn (also known as **Transition Risk**) is the gaining and losing of health insurance coverage. Individuals that experience a change in circumstances during the year that impacts their eligibility in the Marketplace or a state insurance affordability program may experience churn to another health coverage program for themselves or their dependents.

Coinsurance is a bill consumers might receive from their health care provider after a visit for a percentage of the cost of care.

COBRA Insurance (also known as **Consolidated Omnibus Budget Reconciliation Act**) is a type of temporary health insurance coverage authorized under federal law (COBRA) that may allow an individual to elect to keep the individual's insurance coverage if the individual's employment ends, the individual loses coverage as a dependent of the covered employee, or another qualifying event occurs. If an individual elects COBRA coverage, the individual pays 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

Common-Law Employee (or **Employee**) is an individual who the Internal Revenue Service (IRS) would consider an employee based on the degree of control an employer has over the individual and the overall relationship between the employer and the individual. This common-law standard is used under the ACA to define an employee. Non-employee directors, sole proprietors, partners, 2% or more shareholders in an S corporation, and a leased employee are not treated as employees.

Conflict of Interest Policy is the state policy document published by the Indiana Department of Insurance (IDOI) by which all Indiana Navigators and AOs must comply. The document discusses what may constitute an actual or potential conflict of interest (i.e. financial interest or conflict of loyalty) and the rules and requirements surrounding such conflicts of interest by which all Indiana Navigators and AOs must comply. As part of the initial and renewal application processes for Indiana Navigators and AOs, the Indiana Navigator or AO must review this policy and submit to the IDOI either the Navigator Conflict of Interest Disclosure Form or AO Conflict of Interest Disclosure Form, agreeing to the terms of the policy and disclosing any actual or potential conflicts of interest.

Consolidated Omnibus Budget Reconciliation Act (see **COBRA Insurance**)

Consumer Assistant is a broad term used to describe individuals or entities providing outreach, education, or enrollment assistance with a Marketplace or an Indiana Health Coverage Program. This term includes agents and brokers, Indiana Navigators, AOs, Federal Navigators, CACs, federal non-Navigator Assistance Personnel, or Champions of Coverage.

Copay (see **Copayment**)

Copayment (also referred to as **Copay**) is flat fee consumers may need to pay before they are seen by the healthcare provider. Some plans may charge copayments for some services and coinsurance for others

Cost-sharing is a common feature of different health insurance plans, and the specific requirements vary between plans. A health plan's cost-sharing policy can be found in their Summary of Benefits and Coverage.

Cost-sharing reduction is a health-plan discount on a Marketplace that lowers the amount a consumer has to pay out-of-pocket for deductibles, coinsurance, and copayments. A CSR is offered in addition to Premium Tax Credits (PTCs). Qualifying individuals do not have to apply for a CSR separately if the individual meets all requirements for a PTC, is enrolled in a Silver Plan on the federal Marketplace, and whose household income is between 100% and 250% Federal Poverty Level (FPL) (or between 100% and 300% FPL for Native Americans).

Coverage (see **Health Insurance**)

Deductible is a set amount that the individual will spend toward healthcare before the insurance carrier begins to make payments. Once the deductible is met, the carrier may require only copayments, may split costs of care with the individual (coinsurance), or may pay for the entire cost of care.

Department of Health and Human Services (HHS) is the United States federal government's principal health agency. HHS developed and manages the federal Marketplace and manages the establishment, training, certification, monitoring, and oversight of Marketplace agents/brokers, carriers, and federal consumer assistants.

Dependant is a child up to 26 years old under the Affordable Care Act. The Affordable Care Act requires plans and issuers that offer dependent coverage to make the coverage available until a child reaches 26 years old. Both married and unmarried children qualify for this coverage. This rule applies to all plans in the individual market and to new employer plans. It also applies to existing employer plans unless the adult child has another offer of employer-based coverage (such as through his or her job). Beginning in 2014, children up to age 26 can stay on their parent's employer plan even if they have another offer of coverage through an employer.

Division of Family Resources (DFR) is a division of the Indiana Family and Social Services Administration (FSSA), which establishes eligibility for Medicaid, the Supplemental Nutrition Assistance Program (SNAP - food assistance), and the Temporary Assistance for Needy Families (TANF - cash assistance). DFR also manages the DFR Benefits Portal, where consumers may apply for an Indiana Health Coverage Program (IHCP).

Eligibility Group (also referred to as **Aid Category**) refers to a particular group/category that is eligible for Medicaid. An individual is determined eligible for the appropriate group/category based on factors of eligibility such as age, income, pregnancy, disability or blindness. See Table 29 for the 2014 list of Medicaid eligibility groups.

Eligibility Hierarchy is the system used to determine a Medicaid applicant's eligibility for the most comprehensive Medicaid benefit package, in the absence of a stated preference.

Eligibility Redetermination is the process by which an enrolled consumer is re-enrolled, terminated, or transferred into State Medicaid or the federal Marketplace. The eligibility redetermination is to ensure that consumers are still eligible and in the right programs. The process is done every 12 months OR when the enrollee reports any changes to household income, household size, or residence.

Employee (see **Common-Law Employee**)

Employer Mandate (also referred to as **Employer Shared-Responsibility**) is the ACA requirement that, stating January 1, 2015, employers with more than 50 full-time equivalent employees (FTEs) will be subject to tax penalties if at least one FTE receives a Premium Tax Credit (PTC).

Employer Shared-Responsibility (see **Employer Mandate**)

Enrollment Period is the time period in which certain individuals can apply and enroll for health coverage through the federal Marketplace. The term includes an open enrollment period, special enrollment period, and SHOP enrollment period.

Essential Health Benefit (EHB) is a type of benefit that insurance carriers in the individual and small group markets are required to cover. Starting in 2014, the ACA requires health plans to cover certain benefits in each of the 10 EHB categories. Within each of the EHB categories exact benefits may vary by state, the state selects a "benchmark" plan, and the selected plan sets a baseline of benefits that must be covered by other plans.

Ethics refers to the set of standards that an Indiana Navigator or Application Organizations (AO) must follow in order to better improve consumer access to accurate, unbiased information regarding the range of health coverage options. These standards include a commitment to consumers; self-determination; informed consent; competence; cultural competence and social diversity; adherence to conflicts of interest and privacy and confidentiality standards; access to records; and professional conduct.

Exchange (see **Marketplace**)

Explanation of Benefits (EOB) is a document that describes what an insurer paid for a health service accessed by a consumer enrolled in one of the insurer's health insurance policies, what the consumer paid and/or owes for the service, and a summary of the consumer's remaining deductible and out-of-pocket maximum amounts. Each time a health service is accessed by a consumer, the consumer will receive an EOB from their insurer.

Family and Social Services Administration (FSSA) is a healthcare and social service funding agency within the Indiana state government. Most of FSSA's budget is paid to thousands of Hoosier healthcare service providers. The five care divisions within FSSA include the Division of Family Resources (DFR), Office of Medicaid Policy and Planning (OMPP), Division of Disability and Rehabilitative Services (DDRS), Division of Mental Health and Addiction (DMHA), and Division on Aging. FSSA has the authority, along with the Indiana Department of Insurance (IDOI), to implement and enforce the provisions of Indiana Code 27-19, which establishes Indiana Navigator and AO standards in relation to the federal Marketplace and Indiana Health Coverage Programs (IHCPs) operating in Indiana.

Family Planning Eligibility Program is an Indiana Medicaid program that allows eligible men and women the ability to receive certain family planning services and supplies for the primary purpose of preventing or delaying pregnancy.

Federal Marketplace (also referred to as **Federally-facilitated Marketplace (FFM)**) is a federally-developed and federally-operated Marketplace that makes qualified health plans (QHPs) available to qualified individuals and/or qualified employers in accordance with the Affordable Care Act. The current federal Marketplace website (Healthcare.gov) was developed and is operated by the U.S. Department of Health and Human Services (HHS). HHS also oversees the establishment, training, monitoring, and oversight of federal consumer assistance programs (i.e., federal Navigators and CACs) that provide Marketplace outreach, education, and enrollment services. This is the Marketplace model used in Indiana.

Federal Navigator, established under the ACA (42 U.S.C. 18031(i)) and 45 C.F.R. 155.210, is an entity or individual trained, certified, and provided with grant-funding by the federal government to provide Marketplace outreach, education, and enrollment services. Federal Navigators serving in Indiana must complete the Indiana Navigator certification process or AO registration process with the Indiana Department of Insurance.

Federal Poverty Level (FPL) is a figure released each year by the federal government that estimates the minimum amount an individual or family would need to make to cover basic living expenses. Measure reflects income and household size, and changes annually. For 2014, the FPL for a single person is $973 per month, and $1,988 per month for a family of four.

Federally-facilitated Marketplace (FFM) (see **Federal Marketplace**)

Fee-for-Service (see **Traditional Medicaid**)

Flexible Spending Account (FSA) is a medical savings account that allows an individual and the individual's employer to contribute pre-tax dollars towards the cost of future medical costs. Unlike a Health Savings Account (HSA) or Health Reimbursement Account (HRA), funds in the FSA expire at the end of the year.

Free Look Period is a period where a new insurance policy owner is able to terminate the contract without penalties such as surrender charges. A Free Look Period allows the contract holder to decide whether or not to keep the insurance policy. If the contract purchaser is not satisfied with the policy, the contract purchaser can receive a full refund for it.

Full-time Equivalent Employee (FTE) Count is a method under the ACA to count employees to determine if an employer is a small or large employer. The count includes the sum of both full-time employees and full-time equivalent employees. Full-time employees are the number of employees working an average of 30 hours or more a week. Full-time equivalent employees are the sum of all hours worked by part-time employees (employees working under 30 hours per week) in each week divided by 30.

Gold Plan is a type of Qualified Health Plan (QHP) offered to consumers on a Marketplace. It is designed so that the insurance carrier will pay 80% of covered healthcare expenses with the remaining 20% to be paid by the consumer. The consumer's expenses will be in the form of out-of-pocket fees over and above the cost of the plan's monthly premium. Out-of-pocket expenses in 2014 are capped at $6,350 for individual plans and $12,700 for family plans.

Grandfathered Health Plan is a health insurance policy that was in existence prior to the ACA was signed into law on March 23, 2010, and has not had substantial changes. Such a plan does not have to comply with many of the ACA requirements and qualifies as Minimum Essential Coverage (MEC) for the Individual Mandate.

Grandmothered Health Plan (also referred to as **Transitional Health Plan**) is a health insurance policy that was effective after the ACA was signed on March 23, 2010. Grandmothered health plans include some, but not all, of the ACA features, and they cannot be sold on the federal Marketplace. In Indiana, these policies can be renewed through October 1, 2016 as long as they are non-discriminatory (e.g., they do not exclude consumers based on pre-existing conditions). Plans that are renewed must not undergo any material changes and are not required to contain the 10 EHBs or to adopt the rating structure of fully ACA-compliant plans.

Group Market is the market for health insurance coverage offered in connection with a group health plan.

Health Contingent Wellness Program is a program for group health plans that requires an individual to satisfy a standard related to a health factor to obtain a reward (or requires an individual to undertake more than a similarly situated individual based on a health factor in order to obtain the same reward).

Health Insurance (also referred to as **Insurance**, **Benefits**, or **Coverage**) is a type of insurance coverage that provides for the payments of an individual's healthcare/medical costs, including losses from accident, medical expense, disability, or accidental death and dismemberment. Health insurance includes Qualified Health Plans (QHPs) purchased through a Marketplace as well as health plans purchased off the Marketplace, including commercial health insurance products, Indiana Health Coverage Programs (IHCPs), and Medicare.

Health Insurance Benefits (see **Health Insurance**)

Health Insurance Carrier (see **Insurer**)

Health Insurance Coverage (see **Health Insurance**)

Health Insurance Insurer (see **Insurer**)

Health Insurance Issuer (see **Insurer**)

Health Maintenance Organization (HMO) is a designation given to health insurers offering products or services in any market segment (individual, small group, large group, or self-insured) in order to also provide or arrange for the delivery of health care services to enrollees on a prepaid basis. Individuals covered under a HMO will have a prescribed set of providers that may provide covered services. Except for certain services, including emergency services, HMOs are not required to cover services provided by out of network providers.

Health Plan Category (see **Metal Tier**)

Health Reimbursement Account (HRA) is an employer-funded medical savings account that reimburses an employee for out-of-pocket medical expenses and health insurance premiums. An HRA is available to consumers enrolled in a high deductible health plan. The funds contributed to the account are not subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses, and unlike a Flexible Spending Account (FSA), funds roll over year to year if the consumer does not spend them.

Health Savings Account (HSA) is a medical savings account that allows the individual and the individual's employer to contribute pre-tax dollars towards the cost of future health costs. Dollars in a HSA do not expire (unlike a FSA) and belong solely to the individual (including the employer contribution), but individuals must pay a penalty if they use the funds for anything other than qualified health care expenses.

Healthcare Provider (see **Provider**)

Healthcare.gov is a health insurance Marketplace website owned and operated by the federal Department of Health and Human Services (HHS) to facilitate the sale of qualified health plans (QHPs) and eligibility for premium tax credits (PTCs) and cost-sharing reductions (CSRs) for consumers in federal Marketplace and Partnership Marketplace states. The website also fragment those consumers who may be eligible for Medicaid, and has a separate portal for small businesses (the SHOP Marketplace).

Healthy Indiana Plan (HIP) is Indiana's health coverage program for Hoosier adults between the ages of 19-64 whose incomes are at or below 100% FPL and who are not covered by Medicare or other Minimum Essential Coverage (MEC). HIP is authorized through an 1115 Waiver with the federal Centers for Medicare & Medicaid Services (CMS). Covered individuals and the State make monthly contributions to a POWER Account.

High Risk Pool (also referred to as **Indiana's High Risk Pool** or **ICHIA (Indiana Comprehensive Health Insurance Association)**) refers to individuals with high risk health conditions that have been historically denied commercial insurance due to their health status. Indiana's High Risk Pool—ICHIA—once provided coverage for these individuals; however, with the ACA market reforms, major medical insurers may no longer deny individuals coverage based on health status. Thus, the ICHIA program is no longer needed, and individuals that once sought coverage through ICHIA can now apply for coverage through the federal Marketplace or directly through an insurer, because they can no longer be denied coverage based on health status.

Home and Community-Based Services (HCBS) Waiver, authorized under Section 1915(c) of the Social Security Act, is an Indiana Medicaid waiver designed to provide an array of services to enrollees to prevent institutionalization. The HCBS waiver "waives" the requirement of an admission to an institution in order for Medicaid to pay for the needed home and community-based services. The different types of HCBS waivers that Indiana offers are outlined in Table 20.

Hoosier Healthwise (HHW) is Indiana Medicaid's program for low income families, pregnant women and children under the age of 19.

ICHIA (Indiana Comprehensive Health Insurance Association) (see **High Risk Pool**)

In-Network Provider is a healthcare provider (such as a hospital, doctor, or health clinic) in a contract with an insurer, agreeing to provide healthcare/medical services at a discounted rate in return for access to a large group of insured individuals. A list of in-network providers can be accessed through an insurer's website or by calling an insurer's consumer help desk.

In-Person Assister (see **Non-Navigator Assistance Personnel**)

In-Person Counselor (see **Non-Navigator Assistance Personnel**)

Indiana Application for Health Coverage (IAHC) is an application for an Indiana Health Coverage Program (IHCP) which may be submitted to DFR either online through the Benefits Portal, by phone, fax, mail, or in-person at a local DFR office. The different methods for submitting an IAHC, as well as contact information, are listed in Table 68.

Indiana Code 27-19, titled "Health Benefit Exchange," is an Indiana state statute that was signed into law by Governor Mike Pence on May 11, 2013. IC 27-19 requires consumer assistants that help Hoosier insurance consumers with applications for qualified health plans (QHPs) on the federal Marketplace or applications for Indiana Health Coverage Programs (IHCPs) to be certified or registered with the State of Indiana. IC 27-19 refers to these state consumer assistants as Indiana "Navigators" and "Application Organizations" (AOs), and provides certain requirements and guidelines for these consumer assistants. IC 27-19 gives the Indiana Department of Insurance (IDOI) the authority to implement and enforce the provisions established in this code.

Indiana Department of Insurance (IDOI) is an agency of the Indiana state government whose duty is to monitor and regulate the business of insurance in Indiana and give Hoosier consumers information on their options for obtaining insurance. IDOI has the authority, along with FSSA, to implement and enforce the provisions of Indiana Code 27-19, which establishes Indiana Navigator and AO standards in relation to the federal Marketplace and Indiana Health Coverage Programs (IHCPs) operating in Indiana.

Indiana Health Coverage Program (IHCP) is a term that refers to any of the several programs operated under Indiana Medicaid, which have been developed to address the medical needs of the low income, aged, disabled, blind, pregnant, and other populations meeting the eligibility criteria. Each IHCP has different criteria for eligibility. Types of IHCPs include, but are not limited to, Hoosier Healthwise, Healthy Indiana Plan (HIP), Care Select, Traditional Medicaid, and home and community based waiver services (HCBS). Applications for IHCPs can be accessed through the DFR Benefits Portal at www.dfrbenefits.in.gov.

Indiana Navigator is an individual who assists Hoosier insurance consumers in completing applications for qualified health plans (QHPs) on the federal Marketplace or IHCP applications. An individual that meets the definition of "navigator" under Indiana Code 27-19-2-12 must be certified as an Indiana Navigator with the IDOI and abide by all the standards required of Indiana Navigators. An Indiana Navigator may, but is not required to be associated with an Application Organization.

Individual Mandate (also referred to as **Individual Shared-Responsibility**) is an IRS tax penalty imposed on an individual that does not maintain Minimum Essential Coverage (MEC) for themselves and their dependents nor qualify for any of the exemptions from the MEC requirement.

Individual Market is the market for health insurance coverage offered to individuals other than in connection with a group health plan.

Individual Shared-Responsibility (see **Individual Mandate**)

Insurance Affordability Program refers to either of two programs—Premium Tax Credit (PTC) or Cost-sharing Reduction (CSR)—that was established by the ACA to make insurance premiums and cost-sharing more affordable through a Marketplace. Eligible consumers may only take advantage of these programs if they apply for coverage through a Marketplace.

Insurer (also referred to as **Issuer** or **Carrier**), for health insurance purposes, is an insurance company, insurance service, or insurance organization, which has a certificate of authority to engage in the business and sale of health insurance policies in a state and which is subject to state law which regulates insurance. This term may include a Health Maintenance Organization (HMO). Indiana Code 27-19-4-3(a)(16) prohibits Indiana Navigators and AOs from receiving consideration from a health insurance issuer in connection with the enrollment of a consumer into a health plan.

Large Employer (also referred to as **Large Group Employer**) is an employer employing an average of at least 51 full-time employees and full-time equivalent employees (FTEs). Starting in 2015, employers with at least 51 full-time and FTE employees (101 beginning in 2016) will be subject to the employer shared-responsibility provisions of the ACA (the "Employer Mandate"). These employers will be subject to a fine levied by the IRS for each month in which they have one or more full-time employees receiving a Premium Tax Credit (PTC). These employers are not eligible for the SHOP Marketplace.

Large Group Employer (see **Large Employer**)

Major Medical Insurance is a health insurance plan that offers individuals comprehensive insurance against potential healthcare costs. Major Medical plans offer coverage for a wide array of health benefits, providers, products, and services. Plans that only cover a specific health condition or service are not Major Medical products. In general, being covered by a Major Medical Insurance product will qualify as Minimum Essential Coverage (MEC) under the Affordable Care Act. However, some Major Medical Insurance products are not considered MEC, for example certain types of student health insurance.

Managed Care Entity (MCE) (also referred to as **Managed Care Organization (MCO)**) is a general term used to describe health plans that are designed to control the quality and cost of healthcare delivery. The term includes models such as a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO). In Indiana Medicaid, benefits are delivered in the Hoosier Healthwise and HIP through MCEs for some populations.

Managed Care Organization (MCO) (see **Managed Care Entity (MCE)**)

Marketplace (also referred to as **Exchange**) is a governmental agency or non-profit entity that makes qualified health plans (QHPs) available to qualified individuals or qualified employers in accordance with the Affordable Care Act. The term includes a Federally-designated Marketplace (FFM or federal Marketplace), a Partnership Marketplace, or a State-based Marketplace. Indiana operates as a federal Marketplace.

Medicaid is a means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act. It provides free or low-cost health insurance coverage to individuals meeting the States' eligibility criteria which are developed within the parameters established by the federal government. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving eligible individuals.

Medicaid Review Team (MRT) is a group that determines a Medicaid applicant's eligibility for Indiana Medicaid based on a disability. To meet the disability requirement, a person must have a significant impairment that is expected to last a minimum of 12 months. The MRT makes this determination and notifies the DFR of its decision.

Medical Loss Ratio (MLR) is the percent of premiums collected by a health insurance carrier and spent on medical services and quality improvement. Under the ACA, carriers must maintain a certain Medical Loss Ratio, which varies by market segment (Large Group 85%, Small Group 80%, Individual 80%). If a carrier does not meet the MLR requirement, individuals and small businesses will receive a refund.

Medicare is a federal insurance program administered by CMS that guarantees access to health insurance for: (1) individuals aged 65 and older who have worked and paid into the program; (2) individuals under 65 with qualifying disabilities; (3) individuals with End Stage Renal Disease; and (4)individuals with Amyotrophic Lateral Sclerosis. Medicare qualifies as Minimum Essential Coverage (MEC) under the ACA and individuals eligible for Medicare and not eligible for the federal Marketplace.

Medicare Savings Program is a Medicaid program that helps Medicare beneficiaries pay for Medicare premiums and cost-sharing. There are four different categories of the Medicare Savings Program described in Table 22.

M.E.D. Works is Indiana's health care program for working people with disabilities. M.E.D. Works members pay premiums based on their income and receive full Medicaid benefits.

Metal Level (see **Metal Tier**)

Metal Plan (see **Metal Tier**)

Metal Tier (also referred to as **Health Plan Category**, **Metal Level**, or **Metal Plan**) refers to any of the four categories of health plans offered in the Marketplace (i.e., Bronze, Silver, Gold, or Platinum). The plans are categorized based on the percentage the plans pay of the average overall cost of providing essential health benefits (EHBs) to consumers. The plan a consumer chooses affects the total amount the consumer will likely spend for EHBs during the year. The percentages the plans will spend, on average, are 60% (Bronze), 70% (Silver), 80% (Gold), and 90% (Platinum).

Miller Trust (also referred to as **Qualified Income Trust (QIT)**) is a legal arrangement for holding funds that allows an individual with income that exceeds 300 percent of the federal Supplemental Security Income benefit rate (also known as the Special Income Limit-$2,163 monthly in 2014) to become eligible for Medicaid coverage of institutional or home and community-based services.

Minimum Essential Coverage (MEC) is a type of health insurance coverage that an individual must have for him/herself and his/her dependent(s) to meet the Individual Mandate under the Affordable Care Act. The list of MEC types is determined by the federal government and is subject to change. Types of coverage not currently considered MEC may apply for recognition as Minimum Essential Coverage. Individuals may receive an exemption from the requirement to maintain Minimum Essential Coverage.

Minimum Value (MV) is the lowest threshold for the value of a health plan under the Affordable Care Act. A plan with MV should cover, on average, at least 60% of the medical costs of a standard population. Individuals offered employer-sponsored coverage that provides MV and that's affordable will not be eligible for a Premium Tax Credit (PTC).

Modified Adjusted Gross Income (MAGI) is a methodology implemented for eligibility effective January 1, 2014 for insurance affordability programs. MAGI equals adjusted gross income plus tax excluded foreign earned income, tax exempt interest and tax exempt Title II Social Security income. MAGI methodologies are applied to individuals applying for Premium Tax Credits and in the Medicaid program to children, pregnant women, parent and caretaker relatives and adults.

Modified Adjusted Gross Income (MAGI) Conversion refers to states' requirements to convert current Medicaid income eligibility standards to a MAGI equivalent as part of the transition to MAGI-based methodologies in 2014. The goal of the MAGI conversion process is to establish a MAGI-based income standard that is not less than the effective income eligibility standard as applied on the date of the Affordable Care Act (ACA) enactment for each eligibility group.

Network Adequacy Standards is provision in the Affordable Care Act (ACA) requiring Marketplace insurers to ensure that the provider networks of each of their Qualified Health Plans (QHPs) are available to all enrollees and meets other standards, such as having essential community providers, maintaining a network that is sufficient in number and types of providers, and making the insurers provider directory for a QHP available to the Marketplace for publication online.

Non-Grandfathered Health Plan is a health insurance policy that does not have "Grandfathered" status (i.e., was not in existence prior to when the ACA was signed into law on March 23, 2010). The term may include a Qualified Health Plan (QHP), Grandmothered (or "Transitional") Plan, or any other health plan on or off the Marketplace that was effective after the ACA became effective.

Non-Modified Adjusted Gross Income (Non-MAGI) Population is a population that is exempt from MAGI methodologies for the Medicaid eligibility determination process. Current Medicaid eligibility methodologies are maintained for Non-MAGI populations in 2014 and beyond. For Medicaid, non-MAGI methodologies are applied to individuals age 65 or older when age is a condition of eligibility, individuals being determined eligible on the basis of blindness or disability, individuals applying for long-term services and supports for which a level of care need is a condition of eligibility, individuals whose eligibility does not require an income determination to be made by the Medicaid agency, individuals applying for Medicare cost-sharing, former foster children under age 26, and deemed newborns.

Non-Navigator Assistance Personnel (also known as **In-Person Assister** or **In-Person Counselor**) is a type of consumer assister intended to exist in Partnership Marketplace states to complement the federal Navigator program while remaining distinct and apart from the Navigator program. These individuals or organizations are trained and able to provide help to consumers, small businesses, and their employees looking for health coverage options through the Marketplace.

Obamacare (see **Affordable Care Act (ACA)**)

Office of Medicaid Policy and Planning (OMPP) is a department within FSSA that administers Medicaid programs and performs medical review of Medicaid disability claims.

Open Enrollment Period is the timeframe in which individuals can apply and enroll in health coverage through the individual Marketplace. The initial open enrollment period was October 1, 2013 through March 31, 2014. The next open enrollment period is November 15, 2014 through February 15, 2015. The annual open enrollment period is to be determined by the Centers for Medicare & Medicaid Services.

Out-of-Network Provider is a healthcare provider that is not contracted with a particular insurer to provide healthcare/medical services at a discounted rate for consumers covered by the insurer. Some out-of-network providers may not accept an individual's health insurance, and payment may be requested up front. For providers that do not accept an individual's health insurance, an individual may submit a form directly to their insurer showing what they paid for the service. If this form is submitted, the amount the enrollee spent for covered services will count toward the plan deductible and out-of-pocket maximum, and if the enrollee has met the deductible the insurer may issue compensation. To determine whether a provider is in-network or out-of-network with an insurer, a list of in-network providers can be accessed through the health insurer's website or by calling the health insurers consumer help desk.

Out-of-pocket Maximum is the greatest amount that a consumer pays for healthcare services in any plan year before the insurance carrier pays 100% of healthcare costs. Out-of-pocket maximum is set by the federal Internal Revenue Service (IRS). For 2014, this maximum amount is $6,350 for an individual and $12,700 for a family.

Partnership Exchange (see **Partnership Marketplace**)

Partnership Marketplace (also referred to as **Partnership Exchange**) is a mix between the federal Marketplace and a State-based Marketplace, which allows a state to assume primary responsibility for certain functions of the Federal Marketplace permanently or as the state works toward operating a State-based Marketplace. These functions may include, for example, plan management or consumer assistance and outreach. Indiana does not follow this Marketplace model, but rather operates as a federal Marketplace.

Patient Protection and Affordable Care Act (PPACA) (see **Affordable Care Act (ACA)**)

Pediatric refers to children under the age of nineteen. Under the ACA, pediatric healthcare services, including oral and vision care, are considered Essential Health Benefits (EHBs) that an insurance carrier in the Individual and Small Group Markets are required to cover.

Personal Wellness and Responsibility Account (see **POWER Account**)

Platinum Plan is a type of Qualified Health Plan (QHP) offered to consumers on a Marketplace. It is designed so that the insurance carrier will pay 90% of covered healthcare expenses with the remaining 10% to be paid by consumers. The consumer's expenses will be in the form of out-of-pocket fees over and above the cost of the plan's monthly premium (which is the highest of the four QHPs/Metal Plans). Out-of-pocket expenses in 2014 are capped at $6,350 for individual plans and $12,700 for family plans.

Policy Year is either: (1) the 12-month period that is designated as the policy year in the policy documents of a grandfathered health plan offered in the individual health insurance market. If there is no designation of a policy year in the policy document (or no such policy document is available), then the policy year is the deductible or limit year used under the coverage. If deductibles or other limits are not imposed on a yearly basis, the policy year is the calendar year. (2) A calendar year for a non-grandfathered health plan offered in the individual health insurance market, or in a market in which the State has merged the individual and small group risk pools, for coverage issued or renewed beginning January 1, 2014.

POWER Account (also referred to as **Personal Wellness and Responsibility Account**) is an account used to pay medical costs for HIP recipients. It is valued at $1,100 per adult. Contributions to the account are made by the State of Indiana and each participant. No participant will pay more than 2% of his/her family income on the plan.

Pre-Authorization (see **Prior Authorization (PA)**)

Preferred Provider Organization (PPO) is a type of health plan that contracts with certain providers (referred to as in "network providers"). Individuals may choose to receive service from among the network providers or may choose to go to an out-of-network provider and in general be subject to greater cost sharing.

Preliminary Eligibility Screening is a technique that Indiana Navigators may use to evaluate whether a consumer would be better suited to apply for an Indiana Health Coverage Program (IHCP) or for health coverage through the federal Marketplace before assisting with a health coverage application. The Indiana Navigator may ask basic questions about United States citizenship/legal resident status, household income, household composition, and refer to the Eligibility Screening Charts (see Table 65, Table 66, and Table 67), in order to better direct the consumer to the type of coverage for which the consumer is most likely eligible.

Premium is the amount that a consumer must periodically pay to the insurance carrier for a health insurance plan. Individuals pay the premium regardless of whether or not they use the health insurance. It is meant to compensate the insurer for bearing the risk of a payout should the insurance agreement's coverage be required. Premiums are usually paid on a monthly basis, but may be quarterly or yearly.

Premium Tax Credit (PTC) (also referred as **Subsidy**) is a tax credit that lowers premium costs for certain eligible individuals to help them afford health coverage purchased through the federal Marketplace. An individual may apply for a PTC through the federal Marketplace, and the federal Marketplace determines the individual's PTC eligibility and maximum PTC amount. To be eligible for a PTC on the federal Marketplace operating in Indiana, an individual must: (1) be a U.S. citizens, national or legal resident of the U.S.; (2) be an Indiana resident; (3) be non-incarcerated; (4) have a household income between 100% and 400% FPL; and (5) have no other MEC or an available MEC with a premium more than 9.5% of household income or that does not provide MV (at least 60% AV). A PTC can be either claimed retroactively when the consumer's taxes are filed or may be paid in advance directly to the health insurer to reduce premiums (this advanced PTC is referred to as an **Advanced Premium Tax Credit (APTC)**).

Presumptive Eligibility (PE) is a determination by a Qualified Provider that an individual is eligible for Medicaid benefits on the basis of preliminary self-declared information that the individual has gross income at or below the applicable Medicaid income eligibility standard. Indiana operates two PE programs, PE for Pregnant Women and Hospital PE. PE for pregnant women (also referred to as "Managed Care") provides temporary coverage of prenatal care services (Package P only). Hospital PE is PE determined by qualified hospitals for pregnant women (Package P only), children under 19, low-income parents and caretakers, the Family Planning Eligibility Program, or former foster children up to age 26.

Presumptive Eligibility (PE) Qualified Entity (see **Qualified Provider**)

Primary Medical Provider (PMP) is a healthcare provider selected or assigned to a beneficiary of a MCE (i.e., HHW or HIP). Once a beneficiary is enrolled in a MCE, the beneficiary then selects a PMP or, if one is not selected within 30 days, the MCE will assign a PMP to the enrollee. Enrollees must see their PMP for all medical care; if specialty services are required the PMP will provide a referral. The PMP receives a monthly administration fee for each member actively assigned to the PMP. Other services are reimbursed on a fee-for-service basis.

Prior Authorization (PA) (also referred to as **Pre-Authorization**) is a process under which the medical necessity of a requested service is reviewed**.**

Privacy and Security Agreement refers to either the Indiana Navigator Privacy and Security Agreement or the Indiana AO Privacy and Security Agreement (two separate forms) published by the IDOI, by which all Indiana Navigators and AOs must comply. The agreement defines what constitutes a consumer's "personal information" and discusses the privacy and security standards that all Indiana Navigators and AOs must follow in order to protect a consumer's personal information. As part of the initial and renewal application processes for Indiana Navigators and AOs, the Indiana Navigator or AO must sign and submit this agreement to the IDOI.

Producer (see **Agent**)

Provider (also referred to as **Healthcare Provider**) is an individual or entity that provides healthcare or medical services to a patient. Common examples include a doctor's office, hospital, or health clinic. A healthcare provider can be either "in-network" (covered) or "out-of-network" (not covered) with the health insurance coverage offered by a health insurance issuer. **Note: a health insurance issuer may sometimes be referred to as a health insurance provider. It is an important distinction to remember that the "health insurance provider" (the provider/issuer/insurer/carrier of the health insurance) is different from the "healthcare provider" (the provider of healthcare or medical services).* To determine whether a provider is in-network or out-of-network with an insurer, a list of in-network providers can be accessed through the health insurer's website or by calling the health insurers consumer help desk.

Qualified Health Plan (QHP) is a health insurance plan that has been certified under the ACA to meet the criteria for availability through a Marketplace. All QHPs sold on the federal Marketplace are certified by federal and state agencies to be sure they provide Minimum Essential Coverage (MEC), cover Essential Health Benefits (EHBs), meet Actuarial Value (AV) standards, appear as Metal Plans (Bronze, Silver, Gold, or Platinum), and meet provider network standards. Like all other non-grandfathered plans, QHPs cannot consider the consumer's health status for the purposes of plan eligibility or plan cost.

Qualified Income Trust (QIT) (see **Miller Trust**)

Qualified Provider (QP) (also referred to as **Presumptive Eligibility (PE) Qualified Entity**) is an entity that is determined by the Indiana State Medicaid Agency to be capable of making determinations of PE and meets all the qualifications established by the state.

Re-enrollment is the yearly process by which consumers enrolled in a Qualified Health Plan (QHP) through the Marketplace take steps to re-enroll in coverage. Enrollment in a QHP lasts for one calendar year, at which time the enrollee must re-enroll in order to be covered through the Marketplace. All individuals enrolled in the federal Marketplace will receive a notice prior to the next open enrollment period asking them to report any changes in circumstances. Any changes reported will be considered by the federal Marketplace in the annual eligibility re-determination.

Rate Review is the process by which a state insurance department may review and approve, deny, or negotiate health insurance premiums offered by insurers on or off the Marketplace. Under its authority granted by the Indiana Code and federal Effective Rate Review Status, the Indiana Department of Insurance (IDOI) reviews and approves/denies/negotiates premiums for all health insurance policies sold to Hoosiers.

Reward refers to either a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism, an additional benefit, or any financial or other incentive (and avoiding a penalty) such as the absence of a premium surcharge or other financial or nonfinancial disincentive.

Right Choices Program is a program designed to provide intense member education, care coordination, and utilization management to eligible Hoosier Healthwise, Care Select, HIP, and Traditional Medicaid members identified as overusing or abusing services.

Seasonal Worker is a worker who performs labor or services on a seasonal basis as defined by the U.S. Secretary of Labor, and retail workers employed exclusively during holiday seasons.

SHOP Enrollment Period is the timeframe in which qualified employers may apply and enroll in the SHOP marketplace. The SHOP enrollment period is a "rolling enrollment period" meaning that, in most circumstances, SHOP coverage may be obtained at any time of the year and is not subject to an open enrollment period. For employers that do not meet minimum participation or minimum contribution requirements, there will be a once annual open enrollment period; all other employers may enroll in the SHOP at any time.

SHOP (Small Business Health Options Program) Marketplace is the federal Marketplace available to small employers to purchase health coverage for their employees. Eligible employers for 2014-2015 must have 50 or fewer full-time equivalent employees. In 2016 and after, employers with 100 and fewer FTEs will be eligible for the SHOP Marketplace. Employers using SHOP can use brokers or can use SHOP independently. SHOP is located online at www.healthcare.gov/small-businesses/.

Silver Plan is a type of Qualified Health Plan (QHP) offered to consumers on a Marketplace. It is designed so that an insurance carrier will pay 70% of covered healthcare expenses with the remaining 30% to be paid by the consumer. The consumer's expenses will be in the form of out-of-pocket fees over and above the cost of the plan's monthly premium (which is the second lowest in Indiana behind the Bronze Plan). Out-of-pocket expenses in 2014 are capped at $6,350 for individual plans and $12,700 for family plans.

Small Employer (also referred to as **Small Group Employer**) is an employer who employs 50 or fewer full-time equivalent employees (FTEs). Starting in 2014, a small employer may purchase health insurance for its employees using the SHOP Marketplace. Employers that have fewer than 25 FTEs may qualify for tax credits on the SHOP Marketplace. Starting in 2016, the amount of FTEs used to define small employer will be raised to 100 full-time equivalent employees.

Small Group Employer (see **Small Employer**)

Social Security Administration (SSA) is a federal agency through which Indiana Medicaid disability applications go through, effective June 1, 2014, to determine if an individual is eligible for Medicaid disability. Direct applications to Indiana Medicaid may be made if the applicant is a child, has a recognized religious objection to applying for federal benefits (e.g., Amish), seeks eligibility under the M.E.D. Works medically improved category, or cites other "good cause" for not applying to SSA.

Social Security Disability Insurance (SSDI) is a federal insurance program that provides benefits to qualified individuals who can no longer work. To be eligible, the individual must meet the SSA's definition of disabled. Disabled individuals with SSDI are eligible for Medicaid disability insurance in Indiana and need not undergo the state Medicaid Review Team (MRT) process. SSDI is also a source used to determine a consumer's disability status through the federal Marketplace application.

Stand-Alone Dental Plan refers to the dental-only health insurance plans offered through the Health Insurance Marketplace. Individuals can get dental coverage in two ways: as part of a health plan, or by itself through a separate, Stand-Alone Dental Plan. Under the ACA, dental coverage is considered an Essential Health Benefit (EHB) for children under age 18, but is not considered an EHB for adults ages 18 and over. Therefore, insurers are not required to offer adult dental coverage, and adults will not be penalized for not having dental coverage.

Subsidy (see **Premium Tax Credit (PTC)**)

Supplemental Nutrition Assistance Program (SNAP) is a federal aid program administered by the Food and Nutrition Service of the U.S. Department of Agriculture (USDA, which provides food assistance to low and no income people and families living in the United States. Distribution of SNAP benefits occurs at the state level. In Indiana, the FSSA is responsible for ensuring federal regulations are initially implemented and consistently applied in each county. Additional information on the program can be found on FSSA's website at www.in.gov/fssa/dfr/2691.htm.

Supplemental Security Income (SSI) is a federal program that pays benefits to adults and children determined disabled by the SSA and who have limited income and resources. Individuals receiving SSI are automatically deemed eligible for Medicaid disability insurance in Indiana. SSI is also a source used to determine a consumer's disability status through the federal Marketplace application.

Special Enrollment Period is a timeframe outside of the open enrollment period in which a consumer may enroll in health coverage through the Marketplace due to certain qualifying life events, such as losing access to employer-sponsored coverage, marriage, divorce, a birth or adoption of a child, etc. A list of life events that qualify for a special enrollment period is outlined in Table 63.

Spend-Down Program was a Medicaid program that, prior to June 1, 2014, was available to individuals whose income or resources are too high to qualify for Medicaid, but they otherwise met the Medicaid eligibility criteria based on age, blindness or disability. As of June 1, 2014, the Medicaid spend down program is no longer in effect.

State-based Marketplace is a Marketplace developed and operated by a state to make qualified health plans (QHPs) available to qualified individuals or qualified employers in accordance with the Patient Protection and Affordable Care Act. Indiana does not follow this Marketplace model, but rather operates as a federal Marketplace.

Temporary Assistance for Needy Families (TANF) is a federal program that provides cash assistance and supportive services to assist families with children under age 18, helping them achieve economic self-sufficiency. Hoosiers can apply for TANF online at www.dfrbenefits.in.gov, by phone at 1-800-403-0864, or by visiting a DFR local office listed at www.in.gov/fssa/dfr/2999.htm.

Traditional Medicaid (also referred to as **Fee-for-Service**) is a program created to provide healthcare coverage to individuals with low incomes. In Traditional Medicaid, beneficiaries are not enrolled in a Managed Care Entity (MCE) or Care Management Organization (CMO) and can see any IHCP-enrolled provider. All provider claims are paid fee-for-service by the State's Fiscal Agent, Hewlett-Packard. Only certain eligibility groups are covered by Traditional Medicaid.

Transition Risk (see **Churn**)

Transitional Health Plan (see **Grandmothered Health Plan**)

Transitional Medical Assistance (TMA) is a program that provides continued Medicaid coverage to Medicaid-enrolled parents, caretaker relatives or children under 19 who lose Medicaid eligibility due to increased earnings of the parent or caretaker relative.

Web Interchange is a secure website operated by the IHCP to allow IHCP-enrolled providers to check member eligibility, receive information on claims payment, update their provider profile and submit PE applications.

Wellness Program is a program of health promotion or disease prevention. Participation in such a program may result in lower premiums or other cost-sharing.

Common Acronyms

ACA	Affordable Care Act
AGI	Adjusted Gross Income
AO	Application Organization
APTC	Advance Premium Tax Credit (a type of Premium Tax Credit (PTC))
AV	Actuarial Value
BPHC	Behavioral and Primary Healthcare Coordination Program
CAC	Certified Application Counselor
CHIP	Children's Health Insurance Program
CMO	Care Management Organization
CMS	Centers for Medicare and Medicaid
CSR	Cost-sharing Reduction
DFR	Division of Family Resources
EHB	Essential Health Benefits
EOB	Explanation of Benefits
FFE	Federally-Facilitated Exchange (also known as Federally-Facilitated Marketplace (FFM))
FFM	Federally-Facilitated Marketplace (also known as Federally-Facilitated Exchange (FFE))
FFS	Fee for Service
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
FSSA	Family and Social Services Administration
FTE	Full-time Equivalent Employee
HCBS	Home and Community-Based Services Waiver
HHS	Department of Health and Human Services
HHW	Hoosier Healthwise
HIP	Healthy Indiana Plan
HMO	Health Maintenance Organization
HRA	Health Reimbursement Account
HSA	Health Savings Account
IAHC	Indiana Application for Health Coverage
IDOI	Indiana Department of Insurance
IHCP	Indiana Health Coverage Program
MAGI	Modified Adjusted Gross Income
MCE	Managed Care Entity (also known as Managed Care Organization (MCO))
MCO	Managed Care Organization (also known as Managed Care Entity (MCE))
MEC	Minimum Essential Coverage
MV	Minimum Value
MLR	Medical Loss Ratio
MRT	Medicaid Review Team

OMPP	Office of Medicaid Policy and Planning
PA	Prior Authorization
PE	Presumptive Eligibility
PMP	Primary Medical Provider
POWER	Personal Wellness and Responsibility Account
PPACA	Patient Protection and Affordable Care Act
PPO	Preferred Provider Organization
PTC	Premium Tax Credit (one type is called Advanced Premium Tax Credit (APTC))
QHP	Qualified Health Plan
QIT	Qualified Income Trust (also referred to as Miller Trust)
QP	Qualified Provider
SHOP	Small Business Health Insurance Options Program
SNAP	Supplemental Nutrition Assistance Program
SSA	Social Security Administration
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TMA	Transitional Medical Assistance